

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM STATE FISCAL YEARS 1970 TO 2004

Origin and Purpose of the Medicaid Program

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and services within a state can change during the year.

North Carolina Medicaid Program

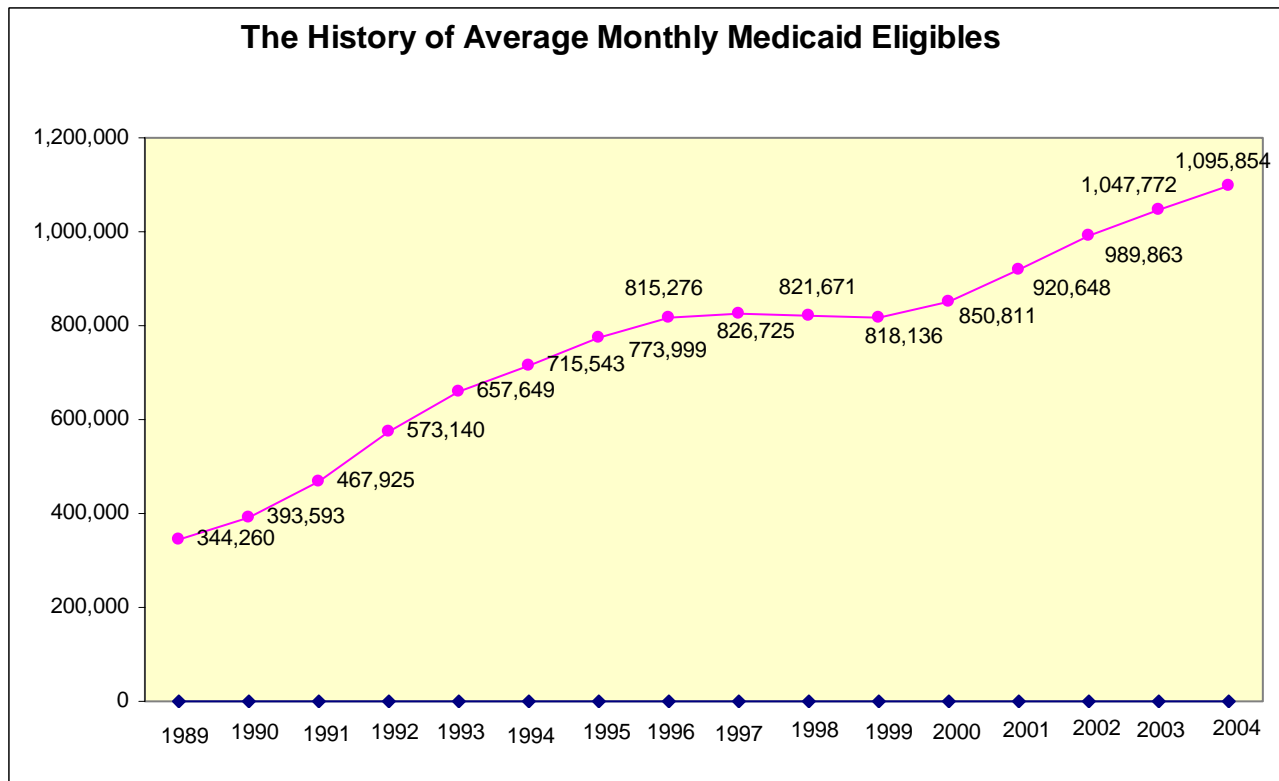
The State of North Carolina submitted its Medicaid State Plan to the Health Care Financing Administration in 1969 and received approval that year. North Carolina General Statutes, Chapter 108A is the law that implemented Title XIX in North Carolina, thus beginning the NC Medicaid Program, on January 1, 1970 under the direction of the North Carolina Division of Social Services. G.S. 108A defined certain technical aspects of the North Carolina Medicaid Program not spelled out in Federal law. North Carolina Administrative Code, Title 10, Chapter 50 and Chapter 26, provided further definition of North Carolina Medicaid policy not addressed in Federal law and regulation nor State law. Each year new legislation that is passed by the North Carolina General Assembly establishes changes to the program and its policies such as eligibility and benefit coverage expansions and contractions, management and administrative mandates, special funding, etc.

In 1978, the NC Medicaid Program was moved to the newly-created Division of Medical Assistance (DMA), a separate division within the Department of Human Resources, which has since been renamed the Department of Health and Human Services. From 1978 to 2004, the annual number of people eligible for Medicaid has increased from 456,000 to 1,512,360 and Medicaid expenditures have grown from approximately \$307 million to \$7.4 billion. As shown below, the number of average monthly eligibles has increased from 344,260 during SFY 1989 to 1,095,854 during SFY 2004.

In 36 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of recipients. However, DMA has historically spent a modest percentage of its budget on administration, which during SFY 2004 was approximately \$172 million or 2 percent of total expenditures.

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Historical Highlights

Over the years, through the leadership of the State Government, the commitment of the taxpayers and the participation of staff, providers and, most importantly, the recipients of Medicaid services, the program has evolved into an essential element of the healthcare system in North Carolina. While it is beyond the scope of this summary document to adequately recognize all of the contributions of the participants and accomplishments of the organization, brief mention will be made of the highlights during each of the fiscal years that the program has been in existence. A more comprehensive description of the current status of the NC Medicaid Program can be accessed through the on-line version of the State Fiscal Year 2004 Medicaid Annual Report and other linked documents on the DMA website at <http://www.dhhs.state.nc.us/dma/annreport.htm>

1970

The North Carolina General Assembly established a medical assistance program in accordance with Title XIX of the Social Security Act and implementation was accomplished on January 1, 1970. The program was initially administered by the Department of Social Services through a contract with Blue Cross/Blue Shield of North Carolina. Services were provided to the categorically needy (persons receiving cash

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assistance) and to the medically needy (persons not receiving financial assistance, but in need of medical subsidy).

1971

No historical notes for this year.

1972

Medicaid service coverage was expanded to include: Early and Periodic Screening, Diagnosis and Treatment; Inpatient Mental Hospital Services for the Over 65; and Mental Health Centers.

1973

On July 1, 1973, the Executive Organization Act created the Department of Human Resources as an umbrella agency over all human services programs. Medicaid was administered by the Medical Services Section of the Division of Social Services.

Nursing home coverage was extended to the medically needy. On July 1, 1973, intermediate care facility services and mental hospital inpatient services for the under age 21 and coverage of children in foster care, in both public and private agencies, were added.

1974

On January 1, 1974, Supplemental Security Income (SSI) became effective. This program administered federal assistance payments to the aged, blind and disabled and relieved the state of this responsibility. At that time, states had the option of extending Medicaid coverage to all SSI recipients and an administrative option for the Social Security Administration to accomplish all eligibility determinations. North Carolina declined both options, choosing to administer its own program and to employ more restrictive eligibility criteria for adults, thus becoming what is termed a "209(b)" state, referring to the pertinent regulatory authority.

Later in 1974, clinic services were added to Medicaid covered services and the unborn child provision was implemented as a result of court action. The unborn child provision allowed that unborn children may be eligible for AFDC if parental deprivation were present, thus the mother and unborn child may be Medicaid eligible very early in the pregnancy. In June 1975, the court order was reversed on appeal and the unborn child provision was deleted from AFDC and Medicaid regulations.

1975

In May 1975, the State of North Carolina signed a revolutionary contract with Health Applications Systems, Inc. (HAS). Under the contract, HAS assumed full risk for the

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costs of the Medicaid Program, including inflation and increased eligibles, for a fixed monthly fee.

1976

By 1976, HAS had suffered financial losses and the risk aspect of the contract was cancelled. NC Medicaid subsequently contracted with EDS-Federal in 1977 to process its medical claims.

1977

The 1977 General Assembly passed cost containment legislation to enhance third party collections, increase patient co-payment requirements, authorize payment to hospitals for “administrative days”, intensify utilization review activities, increase fraud and abuse prevention efforts, tighten transfer of property allowances in eligibility determinations, require use of generic drugs whenever possible, freeze reimbursement rates on certain services and eliminate Medicaid coverage of dental services effective July 1, 1977. A subsequent court suit and public pressure lead to reinstatement of the dental program on July 1, 1978.

During the year, the Secretary of DHR engaged a consulting firm to make recommendations regarding whether to pay medical claims under a contract with a fiscal agent or to bring such an operation in-house. Upon the consultant’s recommendations, he Secretary made the decision to create a separate Division of Medical Assistance with full responsibility for the Medicaid Program, including policy making, eligibility determination systems, financial analysis and contract procurement and monitoring.

1978

On July 1, 1978, the Division of Medical Assistance was created by directive of the Secretary of the Department of Human Resources and was given full authority for the Medicaid Program. One hundred and forty-three positions from the Department of Social Services were transferred to the new division, which was first directed by James E. Gibson, Jr., former Chief of the DSS Medical Services Section. Efforts were focused on reducing fragmentation of Medicaid functions, solving existing eligibility determination system problems, enhancing third party liability collections and improving outreach, screening and immunizations in the EPSDT program. By the end of SFY 1978, the program was serving an average 314,627 eligibles monthly and had made annual vendor payments of \$288,297,761.

1979

Medicaid served 340,000 recipients at a total cost of \$379,769,848 through over 10,000 private providers, 150 in-state hospitals, 250 nursing homes, mental health clinics, county health departments and 7 State mental facilities and 4 specialty hospitals.

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1980

A major goal of DMA during the year was to shift a portion of long-term care from institutional settings to more cost-effective home-based and outpatient settings. Home health expenditures increase by 87% during the year.

1981

Payments for services, combined with greater utilization, resulted in a 23.8% increase in expenditures over the previous year. Progress in the Medicaid program included an increase in health screenings of children. Children also benefited when Medicaid included coverage of developmental Evaluation Centers under the clinic program.

A major eligibility loophole was closed by the General Assembly when it passed a law prohibiting people from giving away assets solely for the purpose of meeting Medicaid eligibility requirements. A lock-in system was designed to control utilization of services by identified over-users.

1982

Medicaid focused on the development of home and community based long term care. Another long term project was the development of prepaid primary care programs, in which a physician or group of physicians provide or arrange for all the health care received by an individual. This system of care was intended to result in lower costs and healthier people.

The Omnibus Reconciliation Act of 1981 reduced the federal matching rate for Medicaid expenditures by 3%, 4%, and 4.5% respectively during the following three federal fiscal years. For North Carolina this meant the federal match for the last three quarters of State fiscal 1981-82 was 97% of the established rate (67.81%). In order to deal with the loss in federal funds in all areas of state government, a special session of the North Carolina General Assembly was held in October 1981. Legislative action during this session imposed restrictions on certain Medicaid services. Prior to December 1981, service limitations were based only on medical necessity. Effective December 1981, these restrictions were 1) eighteen visits per year were allowed to one or a combination of physicians, clinics, hospital outpatient departments, chiropractors, podiatrists, and optometrists, 2) eighteen visits per year were allowed to a mental health center and 3) four prescriptions, including refills, were allowed each month.

Other major changes were made in reimbursement methods. Reimbursement for Intermediate Care Facilities-Mentally Retarded (ICF-MR) was changed from a retrospective to a prospective basis effective October 1, 1981. Inpatient hospital reimbursement was made prospective on November 1, 1981. Effective December 1, 1981 all non-institutional reimbursement rates were frozen at the levels in effect on June 30, 1981.

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Effective February 1, 1982, persons ages 19 and 20 were no longer covered as dependent children in the AFDC category. The Act also mandated coverage of the pregnant woman for states with medically needy programs; therefore, NC DMA began coverage for this group.

1983

In 1982-83 the planning phase for development of home and community based services to help people avoid long term institutional care was completed. The program was initiated in counties on a pilot basis.

Policy changes included:

July 1982	Transfer of responsibility for hospital utilization review from Professional Standards Review Organizations (PSROS) to the state Medicaid staff.
July 1982	Revision of prospective reimbursement for hospital inpatient care on a per diem basis. The purpose of the revision was to provide incentives to lower cost hospitals to serve Medicaid recipients instead of transferring them to higher cost regional care centers.
July 1982	The pharmacy dispensing fee was increased from \$2.80 to \$3.00 per prescription.
July 1982	The freeze on reimbursement to rural health clinics, mental health centers, home health agencies, and other clinics was lifted. Reimbursement rate increases were limited to 7%.
July 1982	Implementation of the Community Alternatives Program for Disabled Adults (CAP/DA) through which services are provided to adults in their own home or in a community setting as an alternative to nursing home placement.
September 1982	Established a Medicaid reimbursement rate equal to the average nursing home rate for recipients in acute care hospitals ready for discharge to Intermediate Care Facilities (ICF) or Skilled Nursing Facilities (SNF), but for whom no appropriate nursing care bed is available.
October 1982	Adoption of a provider fee schedule to encourage participation by primary care physicians in the Medicaid program.
March 1983	Approval by the Health Care Financing Administration of a waiver of federal regulations to allow implementation of a

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prepaid capitation primary care case management program for
AFDC-CN recipients.

1984

In fiscal year 1984, the Division of Medical Assistance concentrated its efforts on two in-home care programs, i.e. the Community Alternatives Programs for Disabled Adults (CAP/DA) and the CAP-MR program for the mentally retarded.

Another priority for the Medicaid program was the promotion of pre-paid health plans. The agency received waivers of federal regulations to allow for reimbursement to pre-paid health groups when the groups are not certified as HMOs. Negotiations continued with potential pre-paid providers. Further, several certified HMOs started operations in North Carolina.

A major step forward was achieved when the agency received authorization and funding from the 1984 General Assembly to provide Medicaid coverage effective January 1, 1985 for all financially eligible pregnant women and children.

Policy changes included:

July 1983	The pharmacy dispensing fee was increased from \$3.00 to \$3.22 per prescription.
July 1983	Implementation of the Community Alternatives Program for the Mentally Retarded (CAP/MR) to provide services to mentally retarded persons in their homes or in a community setting as an alternative to placement in an Intermediate Care Facility for the Mentally Retarded (ICF-MRC).
July 1983	Implementation of a model waiver to provide home based care to children who otherwise would be ineligible for Medicaid at home, but would be eligible in an institution. The program is the Community Alternatives Program for Children (CAP/C).
September 1983	Resource Rule changed for Medically Needy Aged, Blind, Disabled cases to implement \$6,000/6% as mandated by TEFRA of 1982. Non-home property and personal property that is income producing is excluded from resources when the equity in the property does not exceed \$6,000 and the property produces a net annual return of at least 6% of the excludable equity value for each income producing activity. This rule was enjoined by court order in Monies vs Morrow dated July 31, 1984.

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September 1983 First moment of the month reserve rule for Medically Needy Aged, Blind, Disabled as mandated by TEFRA of 1982. For Aged, Blind, Disabled cases not protected by grandfathered provision, eligibility can begin no earlier than the month after countable resources are reduced to allowable limits.

April 1984 Recipient Cost Sharing (Co-Payment) changed.

1985

In an effort to realize long term cost benefits, the agency extended coverage to all pregnant women and all children in two-parent households whose family incomes do not exceed, or who can spenddown to, the medically needy income standards. Medicaid coverage was also extended to children in the custody of private adoption agencies. Prior to this expanded coverage which was effective January 1, 1985, pregnant women and children were Medicaid eligible only when one or both parents were absent from the home or too ill to work.

Highlights in the administration of the Medicaid program in FY 1984-85 include the award to EDS-Federal Corporation of a four year claims processing contract, with an option for an additional year. Another administrative highlight was the decision to cease contracting with a private firm for utilization review activities and inspections of care in nursing homes. DMA decided to perform utilization review activities and contracts with a sister agency, the Division of Facility Services, to conduct inspections of care in nursing homes.

Policy changes included:

July 1984 Pharmacy dispensing fee raised from \$3.22 to \$3.36

October 1984 Maximum net family annual income eligibility standards for Medicaid and AFDC were raised. Medicaid Medically Needy standards were increased 10%. The standards for the Categorically Needy Aged, Blind, and Disabled were increased to those of the Medically Needy.

October 1984 Base year for Long-term Care Direct rates changed to 1983
Maximum direct rates based on 80th percentile instead of 75th

October 1984 Service coverage expanded to SNF/ICF services in a Swing Bed hospital

January 1985 Medicaid coverage was expanded to include the following groups:
- All financially eligible pregnant women

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- Financially eligible children in two-parent families
- Children in the custody of private adoption agencies

February 1985	Service coverage expanded to Pre-paid Health Plans
February 1985	Elimination of the \$6,000/6% reserve rule.
February 1985	Elimination of the first moment of the month reserve rule.

1986

Effective January 1, 1986, adult Medicaid recipients became eligible for an annual health screening. The adult health screening program was patterned after the child health screening program, Healthy Children and Teens. This preventive service is designed to detect health problems, provide early treatment and avoid costly acute services over the longer term. Personal care services were also added on January 1, 1986. These are services provided in the home designed to assist the patient with activities of daily living and related housekeeping activities.

Policy changes included:

July 1985	Pharmacy dispensing fee was raised from \$3.36 to \$3.50
July 1985	Hospital Reimbursement Plan revised to establish a method for setting a reimbursement rate for newly established hospitals and increase per diem rates by 5% to those hospitals serving a disproportionate share of indigent patients.
July 1985	Increase in Resource Limits for the Aged/Blind/Disabled Medically Needy Program.
July 1985	Medically Needy Income Standard increased 10%.
January 1986	Medicaid coverage of Personal Care Services began.
January 1986	Medicaid coverage of Adult Health Screening Services began.

1987

Actions of the 1987 General Assembly in response to Federal legislation enabled pregnant women, infants and young children to qualify for Medicaid based on the federal poverty level and not the traditional AFDC payment level. This initiative is in response to the State's high infant mortality rate and is intended to increase access to prenatal care for low income women and their families.

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Pre-admission authorization for all non-urgent, non-emergency hospital admissions was implemented in November, 1986.

Policy changes included:

July 1986	Pharmacy dispensing fee raised from \$3.50 to \$3.67
November 1986	Preadmission review required for inpatient hospitalization.
November 1986	Therapeutic leave days for Medicaid recipients in long term care increased from 18 to 60 days in any twelve-month period.
January 1987	Medically Needy Income Standards increased 5%.

1988

During 1988 the Division of Medical Assistance and the Division of Health Services successfully launched the *Baby Love* program. *Baby Love* offers pregnant women and their babies early, continuous and comprehensive health care and other needed support services with the anticipated result that there will be a reduction in North Carolina's high rate of infant mortality.

Medicaid also expanded coverage for case management for chronically mentally ill persons. This allows the Division of Mental Health, Mental Retardation, and Substance Abuse Services to provide better access to comprehensive mental health services for this vulnerable population.

Both the *Baby Love* and case management programs are noteworthy for the spirit of cooperation between State administrative agencies in delivering needed services. *Baby Love* has gained national recognition for its achievements.

Medicaid coverage was expanded to include hospice services. The hospice program provides alternative services to terminally ill citizens and helps them achieve the highest possible quality of life during their illness.

Policy changes included:

October 1987	Case Management services covered for target populations Prospective Reimbursement Rate for Home Health Services. Eligibility expansion under SOBRA options to cover all pregnant women and children under age two with incomes under the federal poverty guidelines.
January 1988	Medically Needy Income Standards increased 2.5%. Eligibility expansion to reinstate coverage of 19-21 year olds.

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Eligibility expansion to cover intact families when the primary wage earner is unemployed (AFDC-UP).

April 1988

Hospice covered.

1989

During the year, Medicaid made a number of important changes in coverage and payment for services. Medicaid also instituted a new process for monitoring the appropriateness

and quality of specialized services provided in the home. Further, Medicaid was recognized for achieving the lowest payment error rate in the nation as a result of its ongoing quality assurance activities.

The North Carolina General Assembly authorized Medicaid to take advantage of several options in federal law that expand coverage for pregnant women and children with incomes up to 100% of the federal poverty level including 1) counting only a pregnant woman's income and not her assets in determining her eligibility for care, 2) allowing a pregnant woman to remain eligible throughout her pregnancy and for 60 days after without regard to changes in her income and 3) permitting certain providers, such as health departments and rural health clinics, to grant temporary eligibility for prenatal care. A "presumptively eligible" woman then has 14 days to apply for Medicaid at her county department of social services.

Under this expanded program, pregnant women would receive all services that relate to pregnancy and more young children would receive all necessary Medicaid services. To increase the likelihood that young children receive medical care during their formative years, the General Assembly authorized several increases in the age limit for children who qualify for this special program: to age 3 as of October 1, 1988 and to age 6 as of October 1, 1989.

In February 1989, North Carolina began a new program "Medicare-Aid" that allows Medicaid to pay low income Medicare beneficiaries cost-sharing expenses, such as deductibles, premiums and coinsurance charges. Although enacted as part of the U.S. Congress' Medicare Catastrophic Coverage Act of 1988 (MCCA), the repeal of this bill in December 1989 did not eliminate Medicare-Aid.

Coverage for nurse midwife and private duty nursing services were made available beginning July, 1988. Medicaid eliminated inequitable specialty differentials and began paying the same fee for a service, regardless of provider specialty.

In 1989, the federal government recognized North Carolina for achieving the lowest error rate in the nation for a six month period in 1988. North Carolina had the fifth lowest error rate for the prior period and was second lowest in errors for the year.

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1990

As in SFY 1989, the Medicaid program expanded to cover greater numbers of the state's disadvantaged population. Low income children up to age six were granted eligibility. The income threshold for pregnant women and infants also increased from 100% to

150% of the federal poverty level. According to federal law, the income eligibility threshold for Medicare-Aid recipients increased from 80% to 85% of the federal poverty level.

Policy changes included:

July 1, 1989	Increase dispensing fee for prescriptions (excluding refills) from \$4.04 to \$4.24
August 1, 1989	Increase personal care services hourly rate from \$7 to \$8 Increase hospice care rates
October 1, 1989	Expand coverage of children up to age six in families with incomes under 100 percent of the federal poverty level Increase maternity care rates from \$625 to \$925 (global fee) and from \$350 to \$550 (delivery-only) Increase dispensing fee per prescription (excluding refills) \$4.24 to \$4.85
January 1, 1990	Increase AFDC-related income levels by 2 percent Increase Medicaid eligibility income level for pregnant women and infants under age one to 150 percent of the federal poverty level Increase eligibility income level for Medicare-Aid from 80 percent to 85 percent of the federal poverty level
April 1, 1990	Implement welfare reform 12 month transitional Medicaid coverage benefit

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1991

Medicaid continued to focus available resources on improving the health of North Carolina's mothers, infants and children. Investment in these populations included new coverage of case management services for high risk infants and children and increased provider reimbursement for prenatal care, delivery fees and preventive and primary care services. Carolina ACCESS, a primary care coordination demonstration program, began operation in five counties on April 1, 1991. This program enrolls primary care physicians

to serve as patients' gatekeepers to more specialized--and expensive--services. In return, Medicaid pays participating physicians a modest care coordination fee. The goal of the program is to improve access to primary care and reduce fragmented utilization of expensive services. By so doing, Carolina ACCESS is expected to save program costs.

Carolina ACCESS has received a favorable reception from participating physicians and patients alike.

Policy changes included:

July 1, 1990	Begin direct payments to durable medical equipment suppliers
August 1, 1990	Increase personal care service rate from \$8 to \$9 per hour Mental Health Management of America contract initiated
October 1, 1990	\$750,000 appropriation to provide grants to counties to cover the local share of providing transportation services to Medicaid patients Increase eligibility income level for pregnant women and infants to 185% of the federal poverty level Increase eligibility income level for children ages one to six to 133% of the federal poverty level Expand coverage to children age six in families with incomes under 100% of the federal poverty level Implement federal nursing home reform requirements Increase maternity care rates from \$925 to \$1,100 (global fee) and from \$550 to \$700 (delivery-only) Cover case management for high risk infants and children under age 5

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Cover prosthetics and orthotics for EPSDT-eligible children

Exempt EPSDT-eligible children from the 24 physician visit per year limit and the 6 prescription per month limit

January 1, 1991

Increase physician and dentist fees by 4% (excluding maternity care and laboratory fees)

Increase Medicare-Aid income eligibility level from 85% to 95%

April 1, 1991

Carolina ACCESS demonstration program implemented

Pioneer Project (community mental health center services) implemented

1992

In response to increased outreach efforts targeted to pregnant women and young children, the number of pregnant women who were eligible for Medicaid grew by 16 percent over SFY 1991, while the number of children who were eligible for Medicaid grew by 55 percent.

Carolina ACCESS, a primary care coordination demonstration program, has proven to be a highly successful care delivery model. During FY 1992, the program expanded into twelve counties and enrolled 55,705 Medicaid recipients. This program enrolls primary care physicians to serve as patients' gatekeepers to more specialized--and expensive--services. In return, Medicaid pays participating physicians a modest care coordination fee. The goal of the program is to improve access to primary care and reduce fragmented utilization of expensive services. By so doing, Carolina ACCESS is expected to save program costs. In addition, an independent evaluation credits Carolina ACCESS with saving \$1.5 million annually after its first six months of operation. Carolina ACCESS has received a favorable reception from participating physicians and patients alike.

Policy changes included:

July 1, 1991

Cover transportation for Medicaid eligible pregnant women and children

Cover Qualified Disabled Working Individuals

Expand coverage to children age 7 in families with incomes under 100% of the federal poverty level

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August 1, 1991	Increase personal care services rate from \$9.00 to \$9.36 per hour
August 15, 1991	Increase recipient copayments from \$.50 to \$1.00 for prescription drugs Increase recipient copayments from \$.50 to \$2.00 for physicians
October 1, 1991	Coverage of nutritional counseling, psychosocial counseling and pre-delivery and postpartum home visits for Medicaid pregnant women Expand coverage to children age 8 in families with incomes under 100% of the federal poverty level
December 1, 1991	Direct enrollment of nurse practitioners
January 1, 1992	Direct enrollment of private duty nursing agencies Increase pharmacy dispensing fee from \$4.85 to \$5.60 Increase Medicare-Aid income eligibility level from 95% to 100% of federal poverty level DMA given authority to accept an effective date for provider reimbursement plans as date approved by HCFA for the Medicaid State Plan when APA and the State Plan dates cannot coincide Coverage and enrollment of self-administered home infusion therapy agencies

1993 & 1994

During this period there were no major changes in eligibility policy; however, the number of people eligible for Medicaid grew by 20%. The largest growth occurred in the Special Children coverage group. These are children who are in households with income below poverty, but who are not eligible for AFDC. By June, 1994, children were covered up to the age of eleven.

A major objective of the Medicaid program during this period continued to be greater access and improved services for pregnant women and young children. The Baby Love program and Health Check program were two initiatives designed to achieve these objectives. The two DMA managed care initiatives, Carolina ACCESS and Carolina Alternatives, were also a focal point for Medicaid during this time.

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Policy changes included:

July 1, 1992	Cover screening mammograms for Medicaid eligible women based on age and risk status
	Cover case management services for seriously emotionally disturbed children
August 1, 1992	Increase recipient copayment amounts for Medicaid services to the maximums allowed by federal regulations.
September 1, 1992	Cover Hepatitis B provided to newborns
October 1, 1992	Remove prior approval requirements from most dental services
	Cover case management services for adults and children at risk of abuse, neglect, or exploitation
November 1, 1992	Implement Lead screening and prevention program for Health Check (EPSDT) eligible children
January 1, 1993	Implement the physician fee schedule based on the resource based relative value system (RBRVS)
	Increase in income and resource amounts protected for the at-home spouse of a nursing home patient (Spousal Impoverishment)
	Cover "Specified Low-income Medicare Beneficiaries"
	Implement the Drug Utilization Review Program
July 1, 1993	Cover physical therapy, occupational therapy, psychological services, audiology services and speech language services provided by local education agencies
October 1, 1993	Cover influenza and pneumococcal vaccines for children
January 1, 1994	Implement Carolina Alternatives, a coordinated-care system for the delivery of child mental health and substance abuse services to children 0-18
February 1, 1994	Expand coverage in the CAP program for persons with mental retardation or developmental delays to include prevocational services, supported employment, crisis stabilization, personal emergency response systems and augmentative communication devices

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April 1, 1994	Establish targeted case management services for persons with confirmed medical diagnosis of HIV disease, including eligibility requirements, eligible providers and the reimbursement methodology associated with this service
May 1, 1994	Health Check (EPSDT) introduces a statewide education and outreach program with pilot projects initiated in 21 counties

1995

North Carolina continued to make strides in the managed care arena.

Policy changes included:

October 1, 1994	The General Assembly authorized recovery of medical payments from the estates of deceased recipients who received nursing care in a facility or under CAP.
October 1, 1994	The General Assembly expanded Medicaid coverage for children to age 19 'in families whose income is below 100% of the Federal poverty level.
October 1, 1994	The General Assembly expanded coverage to children placed in adoptive homes and who have special needs for medical care or rehabilitation.
January 1, 1995	The General Assembly authorized Medicaid eligibility for Aged, Blind, and Disabled SSI recipients without a separate Medicaid application or spenddown of income (1634 Status).
January 1, 1995	DMA implemented Diagnosis Related Group (DRG) reimbursement methodology implemented for acute care inpatient reimbursement.
January 1, 1995	DMA expanded the number of individuals who may participate in the Community Alternatives Program for Disabled Adults (CAP/DA) to allow an additional 1,175 persons in the program during the year.
January 1, 1995	DMA increased the number of children who may participate in eligibility for the Community Alternatives Program for Children (CAP/C) from 100 to 200.
January 1, 1995	DMA increased the number of individuals who may participate in the Community Alternatives Program for Persons with Mental

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Retardation/Development Disabilities (CAP-MR/DD) to allow an additional 950 in the program during the year.

- April 1, 1995 DMA implemented the universal American Dental Association (ADA) claim form for Medicaid Dental Billing and prior approval.
- April 1, 1995 DMA added Coverage of additional dental services under Medicaid for children.

1996

Total Medicaid eligibles in the state edged up to 1,176,589, an increase of approximately 38,000 people from the previous fiscal year. AFDC Medicaid eligibles decreased for the second straight year, but large increases in the number of Medicaid Disabled and Medicaid Indigent Children covered were the prime reasons for the overall eligibility increase.

Efforts were focused on expansion of Carolina ACCESS and the Health Care Connection in Mecklenburg County.

Policy changes included:

- July 1, 1995 Creation of a blue ribbon task force by the Legislature to look at the effect of block grant funding and other federal actions on Medicaid in North Carolina.
- October 1, 1995 DMA expanded the Community Alternatives Program for Disabled Adults (CAP/DA) to all counties in the State and obtained Federal approval to increase the potential number of participants by 20 %.
- November 1, 1995 DMA in a cooperative effort with the Division of Health Promotion (DEHNR) to expand services to patients with AIDS implemented the Community Alternatives Program for Persons with AIDS (CAP/AIDS).
- December 1, 1995 DMA obtained Federal approval to continue and expand the Community Alternatives Program for Persons with Mental Retardation/Development Disabilities (CAP-MR/DD), increasing the potential number of participants and the type of services available.

1997

DMA expanded Carolina ACCESS throughout the State with fifty counties on board by year end. The Health Care Connection project in Mecklenburg County ended its first year and appeared to be quite successful.

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Policy changes included:

July 1, 1997 Under the North Carolina Administrative Code, the Division of Medical Assistance was authorized to begin filing claims against estates of deceased Medicaid recipients in order to recover any expenditures made for long-term care for that individual. This policy is mandated by federal law and affects Medicaid applicants as of October 1, 1994.

1998

In May 1998, the General Assembly enacted legislation to provide health care coverage to approximately 71,000 children under federal Title XXI of the Social Security Act. Nationally, the initiative is entitled the State Child Health Insurance Program. On October 1, 1998, this program, under the name Health Choice for Children, began covering children in North Carolina under age 19 in families with income below 200% of poverty. The Department of Health and Human Services has overall responsibility for administering the program, with the Division of Medical Assistance responsible for eligibility determination and premium payment and the Division of Women and Children's Health responsible for outreach. The Teachers and State Employees Health Plan is responsible for benefit coverage and claim payment.

The General Assembly has also enacted legislation to require DMA to reduce the rate of growth in the Medicaid program to 8% per year by the year 2001.

The General Assembly, upon recommendation of the Governor, transferred all Health Services Divisions from the Department of Environment Health and Natural Resources to the Department of Health and Human Services (formerly the Department of Human Resources). Because DMA works so closely with Health Services sections, this was seen as a move to foster more cooperation between the agencies.

While not directly related to Medicaid coverage, the enactment of federal welfare reform legislation and the implementation of the North Carolina Work First welfare reform waiver have resulted in a large reduction in the number in certain categories. The number of Medicaid eligible adults in families has decreased dramatically and the number of children eligible for Medicaid has also decreased.

1999

Responsibility for manufacture of eyeglasses for Medicaid recipients was transferred from an Ohio based private contractor to the NC Department of Corrections. The transfer resulted in reduction of delivery time for eyeglasses and a reduction in cost.

A major policy change was the expansion of Medicaid coverage to aged, blind and disabled individuals with incomes below poverty. This change gave full Medicaid coverage to approximately 40,000 people.

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Policy was changed to provide 12 months continuous Medicaid eligibility for children without regard to changes in family income. Previously, changes in income were required to be reported and changes could result in eligibility determination.

Minor changes in eligibility policies were made to keep consistency between Medicaid policies and changing Work First policies.

2000

Significant effort went into preparing for the Y2K rollover, especially the development of contingency plans in case computer systems failed. Fortunately, the new millenium arrived uneventfully.

The Medicaid Program saw a year of increased expenditures after a major expansion in January 1999, adding coverage for the aged, blind and disabled who have incomes at or below 100% of the Federal Poverty Level. Changes in Medicaid funding of mental health services began to evolve after the mental health managed care program entitled “Carolina Alternatives” ended in March 1999 with a transition period through June 30, 1999.

Health Choice experienced its first full year of operation during State Fiscal Year in some new eligibles for Medicaid, i.e. some children applying for Health Choice learned that they were actually eligible for Medicaid and then enrolled with the Medicaid Program. Efforts to simplify the application process for Health Choice were adopted by Medicaid so that it became much easier to apply for family coverage under Medicaid.

Policy changes included:

- Medicaid physician reimbursement fees were changed to match Medicare rates. The change resulted in increases for most fees and should help improve Medicaid recipients' access to care.
- The definition of “deprived child” was changed by eliminating the requirement that the caretaker relative not work more than 100 hours a month in order to be considered underemployed. This means the deprivation requirement has been entirely removed for eligibility of caretaker relatives and aligns Medicaid policy with Work First.
- Rules were changed to identify professionals who are allowed to give evidence that an individual is incompetent. Statements of lay persons (family and friends) can no longer be used to establish incompetence. A duration requirement was added requiring that the period of incompetence must be at least 30 days.
- Reimbursement methods for ICF/MR facilities were changed to allow payment for services equal to a predetermined rate which is the sum of the provider's direct and indirect costs plus an inflation factor.
- As a result of termination of the Carolina Alternatives waiver, Medicaid criteria for continuing stay in an acute inpatient psychiatric facility were revised and clarified.

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2001

The State was required by regulation to reinstate Medicaid benefits to thousands of Work First recipients whose Medicaid benefits may have been erroneously terminated when their Work First cases terminated. The purpose of the reinstatements was to evaluate ongoing Medicaid eligibility. Recipients, when reinstated, were provided up to four months of Medicaid benefits while staff from local departments of social services

determined eligibility for ongoing benefits. Approximately 80,200 former Medicaid recipients were reinstated, of which 11,319 received on-going benefits beyond the period for which they were reinstated.

The Division has made it easier for Medicaid recipients who work to continue their Medicaid benefits for a few months. This was done by changing the reporting requirements from monthly to quarterly for Medicaid recipients who receive Transitional Medicaid. Transitional Medicaid is an incentive for recipients who have gone to work.

DMA implemented a consumer friendly re-enrollment form for qualified Medicare beneficiaries. The county department of social services can use this form rather than requiring the person to come to the office for a face-to-face interview. The project is part of DMA's efforts to make it easier for people to sign up for Medicaid and stay in the program if they are eligible.

The “Into the Mouths of Babes Initiative” project was launched to provide access to dental care to eligible children from birth to age three. The program's goal is to improve children's access to dental care and, by providing regular preventive care, remove the need for more extensive and expensive care at a later date. The program provides screening for dental disease, applying fluoride varnish to the children's' teeth, and counseling parents and caregivers on proper dental care. Since January 2000, more than 7,500 children have received services and 117 private medical practices and 64 local health departments have been trained to provide services.

In response to the direction set by the N.C. General Assembly and concerns raised by N.C. Legal Services, the Department of Health and Human Services elected to cover psychiatric residential treatment facilities as part of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) mandate. This is an inpatient behavioral health service, below hospital level, that covers both treatment and room-and-board costs.

The Department of Health and Human Services (DHHS) implemented a program to better identify children requiring behavioral health services and to directly enroll High Risk Intervention - Residential (HRI-R) providers into the N.C. Medicaid Program.

The Emergency Department Reimbursement Policy for North Carolina's Primary Care Case Management Program, Carolina ACCESS, was determined by the Health Care Financing Administration (now named “Centers for Medicare and Medicaid Services” or “CMS”) to be out of compliance with the requirements of the Balanced Budget Act

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(BBA). The policy allowed fee-for-service reimbursement for emergency care based on a diagnostic code list of identified emergent conditions. A flat-rate medical screening fee was paid for all other emergency department claims. In September 2000, the policy was changed to pay claims on a fee-for-service basis for all emergency department visits, regardless of diagnosis, in an effort to comply with the BBA requirements.

On February 1, 2001, the Division of Medical Assistance (DMA) began the process of directly enrolling independent mental health providers in a solo or group practice as

Medicaid providers for the provision of mental health services to Medicaid-eligible children ages birth through twenty. This direct enrollment initiative applied to licensed psychologists, licensed clinical social workers, advanced practice psychiatric nurse practitioners, and advanced practice psychiatric clinical nurse specialists.

DMA's Post Payment and Cost Avoidance Unit was responsible for enabling Medicaid to recover or avoid more than \$38 million in costs. North Carolina is a consistent leader in the southeast region for this type of Medicaid recovery.

2002

Various drug utilization measures were implemented (or, in some cases, studied for feasibility) to contain the cost of prescription drugs as recommended by the *North Carolina Medicaid Benefit Study*. They included:

- Establishing a prior authorization program to manage utilization of high-cost, brand name drugs.
- Limiting prescription drugs to a 34-day supply for all drugs, except birth control and hormone replacement therapy.
- Developing physician prescribing practice profiles and other educational tools to enable physicians to better manage their prescriptions.
- Establishing therapeutic limits based on appropriate dosage or usage standards.
- Encouraging use of generic drugs.
- Using maximum allowable pricing.
- Contracting with a pharmacy benefits manager to implement more extensive drug utilization review.
- Studying the impact of eliminating the six-prescription per month limit combined with a more rigorous prior authorization program to ensure cost decisions are determined by using evidence-based clinical guidelines (not implemented).
- Expanding disease management initiatives.
- Working with Carolina ACCESS primary care providers to develop and implement drug utilization management initiatives.
- If cost-effective, expanding Medicaid drug coverage to include selected over-the-counter medications (not implemented).

To ensure appropriate utilization of prescription drugs, DMA implemented a prior authorization process targeting certain prescription drugs that are either very expensive or subject to abuse or over-utilization. Criteria for prior authorization were established on

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clinically sound protocols that were developed according to evidence-based studies and recommendations from DMA's clinical consultants. The largest volume and savings were realized in the Vioxx/Celebrex/Bextra category (approximately \$4 million), followed by Oxycontin (approximately \$1 million), and drugs used to treat ADHD.

The dispensing fee for prescription drugs was reduced from \$5.60 to \$4.00 per prescription for brand name drugs. The dispensing fee for generic drugs remained at \$5.60.


Co-payments for brand name prescription drugs were increased from \$1 to \$3 per prescription. Co-payments for generic prescriptions remained at \$1 per prescription.

Personal Care Services were limited to 3.5 hours per day while maintaining the 80-hour per month limit.

The N.C. General Assembly reinstated medical coverage of routine newborn circumcision.

Rates paid to physicians were reduced to 95 percent of the physician rates paid by Medicare as recommended by the *North Carolina Medicaid Benefit Study*.

Medicare Crossover claims payments were limited to 95 percent of Medicare rates.

Rates for private intermediate care facilities for the mentally retarded were adjusted to  actual costs and to prevent payment rates from exceeding upper payment limits established by Federal regulations.

Annual fee increases for medical and remedial care were limited to percentage amounts authorized by the North Carolina General Assembly. This applied to inpatient hospitals, home health agencies, non-medical inpatient institutions providing personal care services, private duty nursing agencies, durable medical equipment vendors, providers rendering diagnostic screening, preventive and rehabilitative services, and the prospective reimbursement plan for nursing care facilities.

For SFY 2002 only, DMA increased reimbursement rates for 42 dental procedures to address access to care issues for children and adults. This was done in lieu of the annual inflation increase and was budget neutral.

The Medicare indirect medical education factor was adopted by DMA to establish Medicaid reimbursement of indirect medical education.

An additional \$500,000 was provided by the General Assembly to the Community Alternatives Program for Children (CAP-C) and \$1,000,000 to the Community Alternative Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD) in order to allow for additional recipients to be moved from institutional to home and community-based care.

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Medicaid coverage was extended to uninsured women under age 65 with breast or cervical cancer that has been detected through screening carried out under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program.

The legislated 24-visit limit was eliminated for recipients age 21 years and over receiving mental health services subject to utilization review.

Prior approval is required after the eighth visit for recipients 21 years and over receiving mental health services subject to utilization review.

The therapeutic leave policy was changed for nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), psychiatric residential facilities and levels II-IV residential facilities. The change allows providers to hold beds for clients to make therapeutic home visits in an effort to return home permanently.

The Medicare discharge policy is adopted when the discharged patient is assigned to a qualifying diagnosis-related group. The policy applies when the discharge is to a hospital or distinct part hospital unit that is excluded from the DRG reimbursement system, a skilled nursing facility or to home under a written plan of care.

On October 1, 2001, ACCESS II was implemented in Mecklenburg County. Medicaid recipients who are eligible to enroll in managed care now have an option of enrolling in ACCESS II or an HMO within the Health Care Connection.

Services may be provided by a Local Education Agency (LEA) to a Medicaid eligible student in the public school setting or setting identified on the student's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). In 2002, the service was expanded to allow Speech/Language Pathology assistants who work under the supervision of an enrolled licensed practitioner to provide treatment services.

2003

Policy and program changes that were implemented during SFY 2003 either as a result of legislative mandates or at the discretion of the Division of Medical Assistance (DMA).

Mandates enacted by the N.C. Legislature included:

Asset Policy Change

DMA adopted the Supplemental Security Income (SSI) method for considering equity value in income-producing property for aged, blind, and disabled persons. Accordingly, Medicaid no longer excludes the entire equity value of income-producing property for eligibles in the Medically Needy category. Any equity over \$6,000 is a countable resource. This change does not affect business property such as an active farm. This policy change applies only to recipients enrolled in Medicaid as of December 1, 2002.

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Additionally, the General Assembly authorized sanctioning transfers of tenancy-in-common interest in real property. The uncompensated transfer of tenancy-in-common interest in real property results in a sanction unless it is transferred to an allowable person.

Transfer of Assets Policy for Specified Home Care Services

Effective with dates of service of February 1, 2003 and after, DMA began to apply the federal transfer of asset policies to Medicaid recipients in the aged, blind, disabled and MQBQ eligibility categories receiving the following services: personal care in private residences, home health services (including the supplies provided by home health agencies), durable medical equipment (including the supplies provided by DME providers), home infusion therapy, supplies on the home health fee schedule provided by private duty nursing providers to their patients (not including nursing care). This policy change was similar to the transfer of assets requirements currently in place for Medicaid recipients of nursing facility and ICF-MR care, as well as for those recipients participating in the Community Alternatives Programs. The policy change did not apply to adult care residents receiving State/County Special Assistance, but it does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories.

Drug Utilization Management

Various drug utilization measures were implemented to expand prescription drug cost containment, including expanding the use of generic drugs and a preferred drug list. One such initiative was the pilot ACCESS II and III Prescription Advantage List (PAL). The ACCESS Program's clinical directors developed a voluntary PAL as an educational resource for physicians in the ACCESS II and III programs and, beginning November 1, 2002, a list of FDA approved drugs was piloted in ACCESS sites. The list placed drugs in the 10 highest cost classes into tiers based solely on their Average Wholesale Price (AWP). This pilot effort was intended to assess physician acceptance of a voluntary list. There was no prior approval process associated with the choice of drugs on the list. Medicaid continued to pay for any medication a physician considered medically necessary for the patient regardless of cost.

Another ACCESS II and III drug utilization initiative, the Nursing Home Polypharmacy Project, was piloted in November 2002. Benefits of the initiative include the potential for use of more appropriate drugs for the elderly and an increase in coordination between pharmacists and physicians. The initiative will be evaluated based on the following aims: decreased prescription drug costs; the preservation or the enhanced quality of prescription-drug related care; and a decrease in other health care service costs.

The Nursing Home Polypharmacy Project represents an effort by the ACCESS Medical Directors team to better manage prescribing practices for a patient population that averages nine prescriptions per month each. The program depends on the interaction and collaboration between the consultant pharmacist and the prescribing physician. Only the physician can authorize the recommended change to a recipient's drug regimen.

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM STATE FISCAL YEARS 1970 TO 2004

The medications in this initiative will be flagged if: 1) they appear on the PAL; 2) they represent a therapeutic duplication; 3) they appear on the Beers list; 4) the length of therapy appears excessive; or 5) the drugs appear on a list developed by a committee of long-term care pharmacists that feature drugs associated with potential significant savings.

Prior Approval of Outpatient Specialized Therapy Services for Children

Beginning October 1, 2002, Medical Review of North Carolina began processing the requests for prior approval of outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech, respiratory and audiological therapy regardless of where the services are provided.

Personal Care Services Limitations

The monthly limit for Personal Care Services was reduced from 80 hours per month to 60 hours per month effective with date of service December 1, 2002.

Pregnant Women Coverage for Minors

The N.C. Legislature mandated a policy change, to be effective October 1, 2002, that would have modified the determination of eligibility for pregnant women coverage for minors by the counting of parental income if the minor is residing in the parents' home as long as the minor has not been married, has not served in the military or has not been legally emancipated. The Centers for Medicare and Medicaid Services denied the State Plan amendment submitted by DMA that would have authorized this change, thus the policy was not changed.

Hospital Payments

NC Medicaid payments to hospitals were reduced by 0.5 percent. This was implemented through system and process changes.

Prospective Rates for Home Health Services

A prospective rate payment system was established for home health services. The new system pays for services based on an assessment of the specific needs of the Medicaid recipient. Payment for services is no longer tied to the number of provider visits.

Optional Services

Coverage of routine circumcision procedures were eliminated effective with date of service December 1, 2002.

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ACCESS II and III Expansion and Cost Savings

The Medicaid budget was reduced to reflect anticipated savings from the expansion of ACCESS II and III care management activities including reducing hospital admissions, reducing emergency department visits, using best prescribing practices, increasing generic prescribing, implementing polypharmacy review, reducing therapy visits and better management of high risk/high cost patients. The entire NC Medicaid Managed Care Program, consisting of Carolina ACCESS, ACCESS II and III, and HMO's has been renamed "Community Care of North Carolina". Enrollment in ACCESS II and III is anticipated to increase gradually from the current level of 250,000 to 650,000. To encourage the expansion of ACCESS II and III networks, effective April 1, 2003, the monthly case management fee for Carolina ACCESS providers not linked with an ACCESS II and III administrative entity was reduced to \$1.00 per member per month, while those linked with ACCESS II and III, and working on care management activities, continued to receive \$2.50 per member per month.

Medicare Issues

Effective with dates of service October 1, 2002, Medicaid medical coverage policy was applied to Medicare crossover claims. Crossover claims are those claims that Medicare submits to DMA for health-care services provided to Medicare-Medicaid dual eligible recipients where Medicare is considered to be the primary payer. By March 1, 2005, Medicaid payment of a dual-eligible's Medicare Part B deductible and co-payments will be limited to the amount that would be paid for the rendered Medicaid service using Medicaid rates.

Case Management Services

Case management services for adults and children were reduced by lowering reimbursement rates, streamlining services and eliminating duplicative services.

Reimbursement Rate Reductions

Reimbursement rates for high-risk intervention, optical services and services provided by ambulatory surgical centers were reduced by 5 percent. Reimbursement rates for durable medical equipment and supplies, home health supplies and home infusion therapy were also reduced.

Medicare Coverage in Nursing Facilities

Effective with dates of service December 1, 2002, DMA began requiring nursing facilities to bill NC Medicaid for services only after the appropriate services had been billed to Medicare.

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Policy changes that were not mandated by the N.C. Legislature included:

HIPAA Compliance

NC Medicaid implemented Health Insurance Portability and Accountability Act (HIPAA) standard transactions on May 1, 2003. Providers were required to submit electronic claims in the pre-HIPAA format until May 1, 2003. After May 1, 2003, Medicaid began accepting electronic claims in the new HIPAA format and will require the new format after October 16, 2003.

Change in Carolina ACCESS Override Policy

Effective September 1, 2002, Carolina ACCESS overrides were no longer approved when an enrollee has failed to establish a medical record with the primary care provider designated on the enrollee's Medicaid identification card.

Outpatient Specialized Therapy Services

Beginning October 1, 2002, Medical Review of North Carolina began processing the requests for prior approval of outpatient specialized therapy services provided to all Medicaid recipients. Therapy services encompass all outpatient treatment for physical, occupational, speech, respiratory and audiological therapy regardless of where the services are provided. Additionally, specific medical necessity criteria were incorporated into the Outpatient Specialized Therapies medical coverage policy.

"Medically Necessary" Replaces "Dispense as Written"

Effective January 1, 2003, the words "medically necessary" written on a prescription were required to dispense a trade or brand name drug, except for antipsychotic drugs and drugs listed in the narrow therapeutic index.

Mental Health Services for HMO Enrollees Provided by Direct-Enrolled Mental Health Providers

Beginning with dates of service on or after February 1, 2003, direct-enrolled mental health providers were allowed to bill Medicaid for services rendered to HMO-enrolled recipients without a referral from the Area Mental Health Authority.

SFY 2004

Policy and program changes that were implemented during SFY 2003 either as a result of legislative mandates or at the discretion of the Division of Medical Assistance (DMA).

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Policy Changes Mandated by the North Carolina Legislature:

Medical Coverage Policy Development

A special provision within the appropriations bill of the 2001 Session mandated the process by which the Division of Medical Assistance (DMA) is to develop, amend and adopt new medical coverage policies. It specified that during the development of new or amended medical policies, DMA must consult with, and seek the advice of, the Physician Advisory Group of the North Carolina Medical Society (NCPAG). A 45-day public comment period is required after NCPAG review and prior to implementation of a new or modified policy. In accordance with a revision of that mandate during the 2003 Session, effective July 1, 2003, DMA must also consult with potentially affected professional societies and associations representing provider groups. The internal DMA policies and procedures for medical coverage policy development were amended to reflect this change.

Cost Avoidance Model for Pharmacy Claims

Since the Fall of 2003, DMA has established a cost avoidance model for pharmacy claims to ensure that claims are billed first to third-party insurers and that NC Medicaid is the payer of last resort.

Drug Utilization Management

Expanded implementation of the various drug utilization management activities to contain the cost of prescription drugs:

- In November 2003, DMA implemented a statewide Prescription Advantage List (PAL) in order to reduce expenditures in the top fifteen most costly therapeutic drug classes.
- Effective October 1, 2003, certain over-the-counter (OTC) medications that provide cost-effective treatment options were added to the NC Medicaid benefit package. The decision for coverage is based on the analysis of the potential cost benefit of using the OTC medication and the recommendations of the NCPAG using an evidence-based approach.
- Effective October 1, 2003, Medicaid-enrolled physicians were given the flexibility to order a 90-day supply of generic, non-controlled, maintenance prescription medications provided there had been a previous 30-day fill of the same medication. The objectives are to simplify prescribing for physicians and patients and to encourage the use of generic drugs.
- Beginning March 4, 2002, DMA implemented a prior authorization (PA) process for certain prescription drugs through a contract with ACS State Healthcare in

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM STATE FISCAL YEARS 1970 TO 2004

Atlanta, Georgia. DMA has continued these efforts as described in Appendix A of this report.

- During the year, Community Care of North Carolina (CCNC), formerly known as ACCESS II and ACCESS III, implemented a polypharmacy program in nursing facilities in order to case manage situations in which patients receive multiple prescriptions (see details under “Community Care of North Carolina Expansion and Cost Savings” in the Major Accomplishments section of this report).

State Transitional Medicaid Coverage

Effective September 1, 2003, an optional twelve months of State Transitional Medicaid Coverage was eliminated. Families remain eligible for twelve months of Medicaid coverage when they go to work and are no longer receiving welfare payments.

Home Care Personal Care Services

The NC Legislature provided funds to maximize federal Medicaid matching funds for Home Care Personal Care Services. These funds were used to implement the PCS Plus Program (described immediately below).

PCS Plus

In December 2002, the NC General Assembly reduced the monthly limit on personal care service (PCS) hours from 80 to 60. However, after those reductions were implemented, it became clear that there were many PCS clients that needed more than 60 hours of PCS per month in order to remain at home. The personal care services policy was modified on November 1, 2003 to establish medical necessity criteria for 20 additional hours of PCS monthly for recipients whose condition requires care that is beyond the standard 60 hour limitation. Recipients receiving these additional hours of PCS are enrolled in DMA’s “PCS Plus” program. Providers must submit a request for prior approval to DMA to put a recipient into the PCS Plus program

Carolina ACCESS II & III

Expanded the Carolina ACCESS II & III programs within the Community Care of North Carolina Program (the NC Medicaid managed care program) by one additional network to a total of 13 networks, representing twenty-four additional counties. During SFY 2004, a total of 326 providers joined the various networks and enrollment increased by 142,669 recipients (34%) to a new total of 539,649 by June 2004.

Medicaid Assessment Program for Skilled Nursing Facilities

Effective October 1, 2003, DMA implemented a Medicaid assessment program, or “provider tax”, for skilled nursing facilities. As mandated by the North Carolina General Assembly, funds realized from these assessments are being used to draw down federal

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM STATE FISCAL YEARS 1970 TO 2004

Medicaid matching funds to implement and support a new reimbursement plan for nursing homes.

New Reimbursement Methodology for Nursing Facilities

As noted above, DMA's nursing facility reimbursement was changed from a "cost-based" to a "prospective, patient acuity-based" methodology. The new system uses the standardized Minimum Data Set (MDS) to calculate the average "case mix" of the patient population and then aligns facility payments with average facility acuity. Under the new system, facilities serving the patients requiring the highest level of care command a higher reimbursement rate. The FL2 patient assessment form is still used for admission purposes, but the skilled and intermediate nursing level of care system (that was formally derived from the FL2) has been replaced by 34 levels of care attributable to the MDS. Based on the patient's acuity level, as further defined by their "Activities of Daily Living" score, the patient is assigned to one of 34 Resource Utilization Groups (RUGs). The RUG indicates the amount of resources, in terms of nursing staff and aide staff, a patient needs. A nursing facility is then reimbursed during the following quarter according to its specific case mix index factor that was determined by the overall MDS and RUG profile established in the preceding quarter. The new system does not apply to state-owned or federally-managed nursing facilities.

Medicaid-related Services to Public School Students with Disabilities

The Department of Health and Human Services (DHHS), the Department of Public Instruction (DPI) and Local Education Agencies (LEAs) were directed to collaborate on the provision of Medicaid-related services for public school students with disabilities. Procedures and guidelines are to be streamlined to ensure that local education agencies receive Medicaid reimbursement in a timely manner for Medicaid-related services and administrative outreach to Medicaid-eligible students with disabilities. Several DMA medical policy changes and LEA training sessions have been completed. New services are in the process of being added to the program. Clear lines of communication have been established between DPI, DMA and the LEAs.

Medicare Enrollment Required

Effective July 1, 2004, NC Medicaid began to deny claims for recipients age 65 and over who were entitled to Medicare benefits but failed to enroll. These individuals will need to enroll in Medicare in order to obtain Medicaid payment for medical expenditures that qualify for payment under Medicare Part B. Additionally, a provider may seek payment for services from Medicaid enrollees who are eligible for, but not enrolled in, Medicare Part B. Legal aliens who have not lived in the United States for five consecutive years are exempt from this requirement. It is worth noting that the NC Medicaid Program pays the Medicare Part B premium for Medicare-eligible recipients through the Medicare-Aid Program (see Addendum B, "Medicare-Aid").

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM STATE FISCAL YEARS 1970 TO 2004

Other Policy Changes :

Special Services: After-Hours

On November 1, 2003, the “Special Services: After Hours” policy was amended to encourage recipients to go to their primary care providers for medical care that is needed outside of regular office hours (which is defined as between 8:00 a.m. and 5:00 p.m., Monday through Friday) instead of using the more expensive option of emergency rooms.

Ultrasonic Osteogenesis Stimulators

Since 1982, the NC Medicaid Program has reimbursed providers for electrical osteogenic stimulation to aid in the repair of long bone fractures. Beginning on February 1, 2004, coverage was added for ultrasonic osteogenesis stimulators for this same purpose.

Ocular Photodynamic Therapy (OPT) with Verteporfin

Coverage was added on April 1, 2004 for a procedure which treats age-related macular degeneration, the most common cause of blindness in the elderly, when it is used in conjunction with the drug Verteporfin.

Electronic Submission of FL2s

For a number of years, “FL2” forms have been used in documenting patient assessment information for nursing facility level of care authorizations. Effective July 1, 2003, providers were given the option of submitting FL2 forms electronically via the new “FL2e” form developed by ProviderLink, Inc. FL2e’s may now be submitted to the NC Medicaid Program’s claims processing contractor EDS through a web-based browser interface.

Special Studies, Reports and Projects Mandated by NC Legislature:

Vision Screening Task Force

Through the NC Physician Advisory Group, DMA convened a nineteen-member task force to review the current Medicaid standards for vision screening for Medicaid-eligible children to determine whether the standards were meeting the vision needs of children. The resulting report of the task force was submitted to the North Carolina Legislature on April 28, 2004. The task force reported that “..... the consensus is that current NC Medicaid policy is adequate to support a comprehensive and effective vision-screening program and does not recommend changes to the current policy at this time.” However, the task force made several recommendations toward strengthening vision services for Medicaid-eligible children, especially vision screening among preschoolers. These recommendations are currently under review by DMA staff.

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM STATE FISCAL YEARS 1970 TO 2004

Audit of CAP/DA Programs by State Auditor

The Office of the State Auditor was mandated to examine the Community Alternatives Program for Disabled Adults (CAP/DA) and report its findings to the North Carolina Study Commission on Aging. On March 1, 2004, the State Auditor reported that “.....just as there is a critical need to capture important information on the utilization of public expenditures for long-term care populations across settings of care, it is equally important to understand the relationship between utilization of services and the medical needs of the recipients. Existing systems of collecting, storing and accessing data are in need of improvement and DHHS is aggressively working towards building the necessary program tools and data systems that will lead to strengthening public policy, developing an improved long-term care service delivery system and evaluating the impact of the improvements over time.” The State Auditor's report on the CAP/DA program noted that DMA has made considerable progress in addressing many of the findings and recommendations made in the audit. DMA continues to use the audit recommendations to make improvements to CAP/DA.

Medicaid Hospital Payments

DHHS was mandated to evaluate all medical payment programs and policies administered by the Department that may affect the future viability and sustainability of financially vulnerable hospitals. A study committee was formed consisting of the DHHS Assistant Secretary for Health, two hospital administrators and representatives of the NC Hospital Association, the Office of Research, Demonstrations and Rural Health Development and DMA. The committee's report, submitted to the North Carolina Legislature on November 12, 2003, found “...among the one hundred and nineteen acute care hospitals in the State there are numerous facilities that are, in fact, financially vulnerable. That is, there are many for which cash flow and reserves mandate that they operate perilously close to the margin. In fact, there are hospitals that appear solvent only by virtue of prior periods of prosperity and for which certain State programs (i.e. Disproportionate Share Hospitals or “DSH”) are absolutely critical.” It further stated that “....the Department continues to recognize the eleven critical access hospitals (CAH's) in the state as financially vulnerable.” It also noted that “...DHHS has recently proposed to take definitive action to uniformly address the vulnerability of the State's CAH's.”

Adult Care Home Personal Care Service Funding Study

DHHS was mandated to review activities and costs related to the provision of care in adult care homes and to determine what costs may be considered to properly maximize allowable reimbursement available through Medicaid personal care services for adult care homes under federal law. DMA is participating on the Adult Care Cost Modeling Committee to study this matter. A report was not mandated by the NC General Assembly.

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM

STATE FISCAL YEARS 1970 TO 2004

A History of Medicaid Expenditures SFYs 1970-2004		
SFY	Expenditures	% Change
1970*	\$ 49,862,059	
1971	\$ 94,463,693	
1972	\$ 105,719,572	12%
1973	\$ 128,631,312	22%
1974	\$ 141,833,487	10%
1975	\$ 184,606,164	30%
1976	\$ 215,741,299	17%
1977	\$ 273,338,697	27%
1978**	\$ 306,691,301	12%
1979	\$ 379,769,848	24%
1980	\$ 410,053,625	8%
1981	\$ 507,602,694	24%
1982	\$ 521,462,961	3%
1983	\$ 570,309,294	9%
1984	\$ 657,763,927	15%
1985	\$ 665,526,678	1%
1986	\$ 758,115,890	14%
1987	\$ 861,175,819	14%
1988	\$ 983,464,113	14%
1989	\$ 1,196,905,351	22%
1990	\$ 1,427,672,567	19%
1991	\$ 1,942,016,092	36%
1992	\$ 2,478,709,587	28%
1993	\$ 2,836,335,468	14%
1994	\$ 3,550,099,377	25%
1995	\$ 3,550,468,230	0%
1996	\$ 4,113,344,777	16%
1997	\$ 4,640,421,917	13%
1998	\$ 4,715,733,033	2%
1999	\$ 4,934,136,597	5%
2000	\$ 5,789,133,085	17%
2001	\$ 7,065,354,618	22%
2002	\$ 7,366,129,429	4%
2003	\$ 7,439,757,929	1%

HISTORY OF NORTH CAROLINA MEDICAID PROGRAM

STATE FISCAL YEARS 1970 TO 2004

A History of Medicaid Expenditures SFYs 1970-2004	
2004***	\$6,615,381,680
* Expenditures for 6 months, as Medicaid Program began Jan 1, 1970	
** DMA was created to manage the NC Medicaid Program	
*** Only includes Fund 1310 Service Expenditures	

A History of Medicaid Eligibles State Fiscal Years 1979-2004		
SFY	Eligibles	% Change
1978-79	453,174	-
1979-80	455,702	0.56%
1980-81	459,364	0.80%
1981-82	425,233	-7.43%
1982-83	415,552	-2.28%
1983-84	407,806	-1.86%
1984-85	414,353	1.61%
1985-86	441,930	6.66%
1986-87	452,025	2.28%
1987-88	481,326	6.48%
1988-89	561,614	16.68%
1989-90	639,351	13.84%
1990-91	753,292	17.82%
1991-92	877,923	16.54%
1992-93	992,697	13.07%
1993-94	1,058,603	6.64%
1994-95	1,138,786	7.57%
1995-96	1,176,589	3.32%
1996-97	1,192,133	1.32%
1997-98	1,197,173	0.42%
1998-99	1,176,819	-1.70%
1999-00	1,221,266	3.78%
2000-01	1,354,593	10.92%
2001-02	1,390,028	2.62%
2002-03	1,447,283	4.12%
2003-04	1,512,360	4.50%